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Master of Public Health Research Project

A Qualitative Approach to Explore the Experiences of Health Care Providers who Treat Patients for Post Traumatic Stress Disorder (PTSD)

By

Mark Killebrew

Submitted in partial fulfillment for Masters of Public Health Degree

Academic Advisor: Cornelia Ramsey, PhD. MSPH

Department of Epidemiology and Community Health

Master of Public Health Program

MPH Research Project: EPID 691

Virginia Commonwealth University

Richmond, VA

14 May, 2010

Acknowledgements

This research project would not have been possible without the support and guidance of many people. First and foremost, the author wishes to express much gratitude to the U.S. Army Nurse Corps for the opportunity to pursue a graduate degree through the Long Term Health Education Training Program. Much appreciation also goes out to the professors and staff of the College of Epidemiology and Community Health for their dedication to higher learning. Last, but certainly not least, a special thanks to Cornelia Ramsey, PhD, MSPH for her guidance and assistance with this study, no endeavor worthwhile goes without challenges.

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Abstract

Post Traumatic Stress Disorder (PTSD) is an anxiety disorder that occurs when people are exposed to stressful, life-threatening experiences. Consequently, after exposure to such an event, many people may experience fear, guilt, or anger and may believe the trauma is reoccurring. According to the National Institute of Mental Health, approximately 5.2 million U.S. adults age 18-54 have PTSD in any given year. The prevalence of PTSD is even more problematic within the military where an estimated 30% of those who have spent time in war zones experiences PTSD. Researchers have been examining the impact of veterans' PTSD symptoms on family relationships, and on children in particular yet there is little understanding of the residual impact of PTSD or its secondary effects on children. This study aims to begin to understand how the health care providers' experiences and acumen may assist patients with addressing PTSD. Additionally, by exploring the treatments and experiences of physicians, further insight and a deeper understanding may be gained on how PTSD impacts family relationships, specifically, hardiness and parental skills. A secondary aim of this study is identify those factors that promote resiliency in hopes of creating new interventions to lessen the

residual effects of PTSD and prevent intergenerational trauma. This study begins to explore the residual impact of PTSD and will contribute to inform future research to design new methods and tools which may assist physicians to address intergenerational PTSD. This study was approved by Virginia Commonwealth University (VCU) Institutional Review Board (IRB).

Background

Post traumatic stress disorder (PTSD) is a common, yet serious psychological disorder that occurs as a result of experiencing a traumatic event. Studies addressing the impact of PTSD have suggested that it affects 1-15% of the population at some point in their lifetime (Tarrier, N., Liversidge, T., Lynsey, G., 2005). The numerous underlying factors and complexities of psychological/emotional disorders like PTSD present enormous challenges to both the health care system and providers. Unique to PTSD is the fact that many of the symptoms that people experience will be resolved within a year without further complications however approximately a third of them will develop a chronic, unremitting course (Kessler R.C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C., 1995). Cognitive-behavioral treatments have been shown to be efficacious through randomized clinical trials (Harvey, A.G., Bryant, R.A. & Tarrier, N., 2006), yet new treatments and methods need to be developed to reach the many sufferers do not seek treatment and those who do may drop out before treatment has been completed (Hembree, E.A. Foa, E.B., Dorfan, N.M., Street, G.P., Kowalski, J., & Tu, X., 2003).

PTSD treatments vary in regards to their scope and what factors they assess. The most common treatment offered to people who have experienced traumatic events is psychotherapy which typically involves a combination of behavioral techniques and cognitive approaches (Solomon, S.D., Gerrity, E.T., & Muff, A.M., 1992). Other popular treatments teach patients to cope with the traumatic experience through stress management or expose (exposure-based treatments) them to the memories of the situation or circumstances under which the traumatic event occurred (Harvey, 2006). Although there has been significant evidence for the efficacy of many of these treatments, there is much less research on other more recently developed

interventions. Some of these promising new methodologies to address the impact of PTSD emphasizes the treatment to be delivered in a group format that involves families and significant others (Glynn, S., Eth, S., Foy, D.W., Randolph, E.T., Urbaitis, M., Boxer, L., et al, 1999) rather than just the individual.

Health Impact of PTSD

In response to the Iraqi and Afghanistan wars and other traumatic events, researchers have been examining the impact of veterans' PTSD symptoms on family relationships, and on children in particular. As a result of research, it has been revealed that family members of individuals with PTSD may experience numerous difficulties resulting from the PTSD of their family members (Kleinfelder, J., Telijohann, S.K., Price, J.H., 2004). This theory that PTSD symptoms can be passed from one generation to the next has been described as intergenerational transmission of trauma or secondary traumatization (Galovski, T., & Lyons, J., 2004). Because PTSD is often identified as mediating the effect of veterans' combat experience on the family, empirical modeling of additional factors involved in secondary traumatization is needed.

The majority of marital/family interventions addressing PTSD have largely focused on improving relationships and reducing veterans' symptoms rather than targeting improvements in the psychological well-being of the spouse and children (Galovski et al., 2004). In addition, there have been virtually little, if any studies documenting the experiences and perspectives of health care providers that may uniquely emphasize and/or incorporate those factors or interventions that might promote resiliency among those who suffer from PTSD. This study aims to begin to understand how the health care providers' experiences and acumen may assist

patients with addressing PTSD. Additionally, by exploring the treatments and experiences of physicians, further insight and a deeper understanding may be gained on how PTSD impacts family relationships, specifically, hardiness and parental skills. A secondary aim of this study is identify those factors that promote resiliency in hopes of creating new interventions to lessen the residual effects of PTSD and prevent intergenerational trauma.

Most research has looked specifically at the impact on the individual. A person who suffers from PTSD may relive the traumatic experience through different types of symptoms that have come to be characterized and defined as PTSD. Through years of research, 17 symptoms of PTSD have been identified (Tull, M., 2009). These symptoms are listed in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV). The 17 symptoms are further classified into three separate clusters. The three types of symptom clusters associated with PTSD are: re-experiencing symptoms, avoidance and numbing symptoms and arousal symptoms (Tull, M., 2009). These symptoms may start to occur soon after a traumatic event, however, for some people, they may be dormant for a period of time. Moreover, these symptoms must persist for at least one month and cause either significant distress or interfere with a person's work or home life for PTSD to be diagnosed (Nebraska Department of Veteran's Affairs, 2007) which also delays treatment.

Other health issues such as alcoholism, depression, substance abuse and anxiety commonly occur along with PTSD. In fact, more than half the men diagnosed with PTSD have problems with alcohol. Depression is the next most common co-occurring health issue for men, followed by conduct disorder and then problems with drugs (Nebraska Department of Veteran's Affairs, 2007). In women, depression is the most common co-occurring health

problem. Just under half of women with PTSD report having depression. Other health issues reported by women include specific fears, social anxiety and problems with alcohol (Nebraska Department of Veteran's Affairs, 2007).

In general, people who develop PTSD have problems with functioning in everyday life. They are at a higher risk for unemployment, problematic interpersonal relationships, divorce or separation, spouse abuse, and violence. Furthermore, people living with PTSD may experience a host of physical health issues and also have an increased likelihood of developing medical disorders (Nebraska Department of Veteran's Affairs, 2007). Depression and anxiety often have co-occurring physical symptoms so it is too soon to draw firm conclusions about the causal association between PTSD and medical disorders. More research is essential to determine this relationship.

PTSD in the General Public

This study focused on the impact of PTSD in military personnel and their families however it is important to acknowledge that PTSD occurs in the general public. Research has indicated that an estimated 38% of people in the U.S. are treated for PTSD in a given year (Kessler, R.C. Zhao, S., Katz, S.J., et al., 1999). In a nationally representative sample, the U.S. National Comorbidity Survey (NCS) found that 7.8% (see Appendices, Figure 1) of respondents had a lifetime history of PTSD (Kessler, 2000). The majority of patients who suffer from PTSD are seen in the medical sector of the healthcare system, while others are in the human services sector (e.g., seen by spiritual counselors or social workers) or the self-help sector. Approximately 22% of those with PTSD are in treatment with a psychiatrist, clinical psychologist, or other mental health professional (Kessler, et al., 2000). The negative health

outcomes associated with trauma and PTSD have important public health implications, given that over half of the adult population in the United States have experienced a traumatic event and 8% have had PTSD at some point (Kessler et al, 1999). Findings from this study will provide information for developing new interventions or revising current methods that may benefit the general public as well as military personnel and their family members.

Prevalence of PTSD in the Military

The current Global War on Terror has brought to the forefront the key impact of PTSD. Epidemiological surveys conducted during the current conflicts in Iraq and Afghanistan suggest that as many as 13% to 17% (see Appendices, Figure 1) of service members screen positive for PTSD (Hoge, C.W., Castro, C.A., Messer, S.C., et al., 2004). The effects and impact of PTSD become even more pervasive as service members endure multiple tours of combat duty. With the advancements of battlefield medicine, more injured soldiers are surviving leaving thousands of young men and women living with both the physical and mental torment of traumatic experiences.

As an Army Public Health Nurse deployed in support of Operation Iraqi Freedom from October 2004 to September 2005, I have witnessed the incredible emotional and physical impact that military personnel are exposed to. While serving as a health care provider with the 82nd Combat Support Hospital, I had the opportunity to see how the ravages of war not only affected those soldiers who were on patrol and involved in combat maneuvers, but the health care providers on the front lines who provided trauma services to the injured and mortally wounded. The daily stress of mending broken, mutilated bodies and tending to the scarred and fragile psyche of young soldiers had to leave an emotional toll that is hard to describe, yet,

undeniably burdensome. How was one to leave this nightmare in the war zone and resume a normal life when back home with family and friends? Furthermore, what resources do people possess or what services do they seek if and/or when they reach their personal threshold to cope with the traumatic events they have been exposed to? These are the questions I asked myself while talking with my colleagues and after witnessing their attitudes and behaviors before, during and after deployment.

The Mental Health Advisory Team (MHAT), established by the Office of the U.S. Army Surgeon General, assessed the mental health of deployed U.S. soldiers in the fall of 2006 (Mental Health Advisory Team, 2006). This team noted that there were increased behavioral health issues among service members who served in multiple deployments. The military standard of practice is to screen all service members before and after combat deployments. The MHAT reported that soldiers who had been deployed to Iraq more than once were more likely to screen positive for acute stress (PTSD), anxiety, depression, or any other mental disorder than soldiers who had been deployed only once (Ursano, R.J., Benedek, D.M., & Fullerton, C.S., 2008.). More specifically, soldiers deployed multiple times were 1.6 times more likely to screen positive for PTSD than those deployed once, and 1.2 and 1.7 more times likely to screen positive for anxiety and depression, respectively. Soldiers deployed more than 6 months were 1.5 to 1.6 times more likely to screen positive for acute stress than those deployed for less than 6 months (Mental Health Advisory Team, 2006).

Review of Research of Military Personnel

A. Individuals

Studies that have examined the interpersonal functioning of combat veterans have shown that Vietnam veterans have more difficulty with intimacy and social conflict (Wilson, J.P., 1978) and have reported more hostility, social isolation (Egendorf, A., Kadushin, C., Laufer, R.S., Rothbart, G. & Sloan, L., 1981), and marital problems (Penk et al., 1981) than control groups. Other studies that have compared veterans with PTSD to those without the disorder have shown that PTSD veterans have significantly more problems with relationship adjustment in general along with self-disclosure, expressiveness, and physical aggression towards their partners (Carroll, E.M., Rueger, D.B., Foy, D.W., & Donahoe, C.P., 1985), intimacy and sociability problems (Roberts, et al., 1982), and more problems related to their social, sexual, family, and work functioning (Solomon, Z., & Mikulincer, M., 1987).

B. Families

Researchers that have explored the impact of war-induced psychopathology in families of veterans with PTSD have revealed an increase in violence and conflict coupled with decreased levels of marital and family adjustment and poorer parenting skills (Jordan et al., 1992; Solomon, Z., Mikulincer, M., Freid, B., & Wosner, Y., 1987). In dealing with such problems, family members of veterans with PTSD may experience a burden of care and may themselves develop psychological symptoms (Beckman, J.C., Lytle, B.L., & Feldman, M.E., 1996). The fact that these marital and family variables are significantly related to the severity of PTSD in combat veterans suggests the need to develop a comprehensive treatment plan or new interventions that may reduce the stress levels in the family. Perhaps the first step in addressing the residual impact of PTSD may arise from the perspective and experiences of those providers who assist patients with PTSD.

Theoretical Framework: Stress and Coping Model Applied to PTSD

A. Stress and Coping Model: Stress and Coping

The varying theoretical models of traumatic stress syndromes and the literature of PTSD have established that there is a wide range of approaches and outcomes that people may exhibit when reacting to traumatic experiences (Bonnano, G.A., 2004; Wilson, J.P., 19995; Wilson, J.P., & Drozdek, B., 2004; Wilson, J.P., Friedman, M.J., & Lindy, J.D., 2001; Wilson, J.P., & Raphael, B., 1993; Zeidner, M., & Endler, N.H., 1996). The Transactional Model of Stress and Coping framework provides a comprehensive approach that allows for evaluating an individual's processes of coping with stressful events. Stressful experiences are construed as transactions between a person and their environment. These transactions depend on the perceived impact of the external stressor. Subsequently, the reaction to the external stressor is mediated initially by the person's appraisal of the stressor and secondly, by the social and cultural resources at the person's disposal (Lazarus, R.S. & Cohen, J.B., 1977; Antonovsky, A. & Kats, R., 1967; Cohen, F., 1984). Central to the Stress and Coping Model are the concepts of primary and secondary appraisals. The primary appraisal constitutes a person's judgment or perception about the significance of an event as stressful, positive, controllable, challenging or irrelevant. In response to the stressor, the secondary appraisal follows. This is an assessment of the person's coping resources or options. Secondary appraisals address what an individual can do about the situation. Actual coping efforts focused on the problem will then determine the outcomes of the coping process.

Generally, people react with specific coping strategies to mediate both primary and secondary appraisals. If the threat or stressor is perceived as controllable or escapable, an

individual may use an active coping strategy like confrontation, fight or escape. Although most people use a number of different types of coping strategies, research has indicated avoidance behaviors, and more particularly escape-avoidance coping, as a significant predictor of posttraumatic morbidity (Charlton, P.F.C. & Thompson, J.A., 1996; Marmar, C.R., Weiss, D.S., Metzler, T.J. & Delucchi, K., 1996; Chang, C.M. Lee, L.C., Connor, K.M., Davidson, J.R.T., Jeffries, K., & Lai, T.J., 2003). Escape-avoidance represents behavioral avoidance through eating, drinking, or smoking and emotional dissociation or disengagement. Both disengagement methods of coping with stress and immediately disengaging from coping efforts significantly increase the likelihood of experiencing ongoing distress and posttrauma stress symptoms (Coffey, P., Leitenberg, H., Henning, K., Turner, T., & Bennett, R.T., 1996). Consequently, these specific coping strategies, or perhaps, the lack of effective coping strategies have an enormous impact on family relationships. Thus, coping should be seen as a process and an understanding of coping in relation to the different types of stressors must take into account how coping with that stressor may change over time (Horowitz, M.J., 1986; Lazarus, R.S., 1966).

B. Proposed Study Model

A great deal has been learned from studies of coping, stress and coping processes, yet considerable less has been learned about the more basic and pressing questions of how coping processes operate (Edwards, J.R., 1988; Folkman, S. & Moskowitz, J.T., 2000). Recent advances with mental health interventions along with emerging needs have provided researchers with exciting opportunities to gain a more comprehensive understanding of how people, families and communities respond to traumatic events. In all areas related to understanding and treating PTSD, it is evident that health care providers are challenged to develop new

interventions and models to address PTSD. In order to either alter or affect some behavioral change in people who have been exposed to a life altering or traumatic event, it is important to also consider other variables outside their social context or environment. Evidence-based and evidence-informed clinical trials have revealed that in efforts to modify individual behavioral risk factors such as drug, alcohol, tobacco use, diet and physical activity, the most successful approaches have incorporated elements of social organizational interventions and changes (Berkman, L.F., Kawachi, I., 2000). Additionally, successful behavioral and health interventions incorporate the social context of the individuals' communities, work sites, and families (Emmons, K.M., 2000; Sorenson, G., Emmons, K., Hunt, M.K., Johnston, D., 1998), especially close family relationships and social support systems.

This study proposes using a modified version of the coping and stress model to address PTSD and how the disorder may impact individuals living in close proximity with someone who may be suffering from PTSD. The main emphasis of this adaptive model is to give a voice to the providers and clinicians to assess how they assist patients with addressing PTSD.

Understanding the specific coping mechanisms that physicians assess with their patients may help to develop new interventions or revise current practices to prevent or alleviate the negative and destructive nature associated with PTSD such as secondary traumatization and the wear and tear on individuals and their families. Some physicians may focus more on the patient's personal methods of dealing with stress and not assess their social, cultural or environmental context. Other providers might emphasize personality traits that may or may not enhance anger management or communication skills. Still others might focus specifically on

approach and avoidance concepts in response to stress rather than focusing on concepts such as hardiness or resiliency factors.

Earlier studies were conducted on families of survivors of the Holocaust (Bergmann & Jucovy, 1982; Epstein, 1979) as well as studies of veterans' families. The term "secondary traumatization" was coined by C.R. Figley in 1983 to describe the residual effects of PTSD (Galovski, et al.). Within this context it is proposed that an individual who has not been directly exposed to a traumatic event would develop PTSD symptoms after learning of such an event indirectly through someone who actually experienced the event. Furthermore, some research suggests that the experience of living with someone suffering from PTSD may render an individual more susceptible to developing PTSD secondary to an unrelated traumatic event (Galovski, et al.). This study proposed to explore the perspective of the health care provider to provide a different, perhaps more keen insight, to comprehend more fully and treat more effectively, those individuals with PTSD and their families.

C. Expanded Scope of Practice

This modified model of stress and coping has been created to assess the experiences and perspectives of the health care providers to evaluate how they assist patients with addressing PTSD. Unique to this model are the constructs of secondary traumatization of PTSD along with the wear and tear on an individual and their family from unresolved PTSD symptoms (see Appendices, Figure 2). A modified framework may help to determine those physician driven interventions and/or assets that might cease the perpetuation of the PTSD cycle, specifically intergenerational PTSD that may impact the family and especially, children.

Although research has indicated that psychotherapy interventions and behavioral techniques have been both efficacious and effective (Solomon, et al., 1992) in treating individuals suffering PTSD, current therapies do little to take into account the residual impact on families and whether health care providers address secondary traumatization when assisting patients. Expanding the scope of practice in terms of assessing for residual effects of PTSD upon family members and others who live in close proximity of PTSD sufferers may provide new techniques or interventions specifically created to address and prevent secondary traumatization while also promoting those factors that may provide resiliency that may prevent PTSD symptoms and other associated health problems. Rather than have the individual ask, “What can I do now?” in regards to reacting or dealing with potential stressors or traumatic events, the central theme of this study applies that same question to the health care provider. Are health care providers who treat patients for PTSD even aware of secondary traumatization or do they take into account how those symptoms impact family members? What tools do health care providers use to quantify the residual impact of PTSD? Is an intuitive acumen more beneficial than scientific instruments when assessing or diagnosing PTSD? Perhaps a more comprehensive understanding of these variables might be used in treating PTSD. How an expanded scope of practice minimizes the residual impact on the family is illustrated in Line A of Figure 3 (see Appendices).

The proposed attributes that distinguish the expanded scope of practice address hardiness, patient personality characteristics, parental skills and self efficacy in addition to the conventional therapy techniques (see Appendices, Figure 4). Certainly each individual brings a number of factors that may contribute to either risk or resiliency to a traumatic event. Whether

these attributes are being sufficiently assessed for or measured when a patient is being treated for PTSD is unknown at this time. Furthermore, an additional aim, yet equally important aspect of this expanded scope of practice is assessing those factors that promote resiliency. The fact that not everyone exposed to a traumatic event develops PTSD indicates that there are some characteristics which serve as a personal resource in adjusting to or preventing PTSD.

Understanding that posttraumatic resiliency is critical to successful treatments must be an integral part of any PTSD assessment. Research (Agaibi, C.E., Wilson, J.P., 2005) has indicated that posttraumatic resiliency is associated with a number of personality and ego traits that allow for behavioral adaptation and personal functioning to stressful events. However, it is not clear if conventional treatments identify or measure these characteristics and how or whether if resilient factors can be learned.

Study Design

A. Formative Study

Due to the complexities associated with developing, assessing and treating PTSD, this formative research proposal uses a qualitative design to more fully explore what physicians' believe and practice. Semi-structured interviews were planned with a small number of physicians at a Veteran's Affairs (VA) hospital. Qualitative research is useful in providing depth and detail through direct interaction with a small number of people or cases (Wilmot, A., n.d.). Typically, complex human behaviors are not well captured by quantitative measures. Statistical inference is not the objective for this study, rather an understanding of the world as seen through the eyes of physicians who assist patients with living with PTSD. By using In-depth interviews with probing, open ended questions, the variations in people's words and actions

may be more completely understood. Despite the long standing and more traditional approach of comprehensive cognitive-behavioral treatment programs for those who suffer from PTSD, a new approach to identify specific patterns or themes might be gained from the insights and perceptions of physicians in regard to the impact of PTSD on their patients.

The many determinants and factors related to PTSD, and specifically, the residual impact or PTSD, are much too complex to be assessed by using simple surveys or yes/no questions. The gold standard for assessing PTSD is a 30-item structured interview known as CAPS (Clinician Administered Patient Survey). This tool was designed to be administered by clinicians and clinical researchers who have a working knowledge of PTSD (Blake, Weather, Nagy, Kaloupek, Charney, & Keane, 1995). It corresponds to the DSM-IV criteria for PTSD and normally takes about 45-60 minutes to be completed. In addition to assessing the 17 PTSD symptoms to diagnose PTSD, the questions target the impact of symptoms on social and occupational functioning, response validity, overall PTSD severity and frequency of symptoms. These questions were reviewed to develop interview questions with physicians and other health care providers rather than patients who suffer from PTSD.

B. Methodology

Based on the Clinician Administered PTSD Scale (CAPS) created by the National Center for PTSD (National Center for PTSD), the interview questions for this proposal have been designed to be flexible and broad, yet effective to generate meaningful results about how physicians address PTSD and its impact on the family. Subsequently, the questions are intended to further explore the residual or intergenerational effects of PTSD through the eyes of the

health care provider. The researcher will conduct all of the semi- structured interviews and will conduct thematic analysis to determine common ideas and themes.

C. Participant Recruitment

For this study, health care providers from the Veteran's Affairs (VA) Medical Center in Richmond, VA were selected to be interviewed due to their expertise with treating patients for PTSD. Due to the high number of military personnel who have endured multiple deployments, the prevalence and impact of PTSD on military personnel and their families is enormous. The VA provides specialized PTSD programs and services to the majority of military veterans and their families. Consequently, VA physicians and clinicians have unique experiences and knowledge with assessing for PTSD. Purposive sampling was implemented to select physicians and providers who possess the extensive training and skill to assess the impact of PTSD. Recruitment of the physicians and clinicians was conducted using the snowballing technique within the VA PTSD Program. The PTSD Program Director was initially contacted for an interview. He provided names of other providers within the VA to be interviewed.

Discussion

A. Lessons Learned

Due to the fact that this study proposal request is pending further review by the Veterans' Affairs Institution Review Board, no specific findings or conclusions were able to be analyzed and disseminated. However, it would be grossly inaccurate to suggest that there were no significant lessons learned from this endeavor. First and foremost, it was important to base interventions on a focused theoretical approach. The Stress and Coping Theory has been

extensively evaluated from a number of clinical studies and has solid empirical support in addressing how PTSD affects individuals through different therapies and interventions.

As a Public Health Nurse serving the military community, there will be opportunities to apply behavioral theory when working with health care providers who assist patients with PTSD. The number of deployments may be winding down for most soldiers however the effects of PTSD are bound to prevalent for years to come. By designing a model to assess the physicians' perspective of assessing PTSD, I was able to see how PTSD affects the lives of individuals and family members on different levels. Thus the research process provided a fresh look at a complex and perplexing health care issue. Attempting to assess how physicians may evaluate individuals with PTSD and the potential residual impacts helped to formulize the research strategy and methodology. This theoretical framework allowed for a flexible, individualized approach adapted for the evaluation of new constructs. It was essential to understand how sampling physicians and using semi-structured interviews to collect data would provide an effective and useful thematic analysis.

Perhaps the most important aspect of this proposal was the development of the modified model created to address a unique and perplexing area in the health care system that plays such a significant role in regards to treating PTSD. The robust literature review that was conducted for this study focused on how the residual impact of PTSD is addressed, it was apparent that few scientific studies have thoroughly explained this phenomenon and provided strong data that might be applied to creating and/or adopting new interventions and methods that might reduce the impact of PTSD. There is a clear need for a framework and instrument to evaluate how physicians assist patients who suffer from PTSD. I believe that the approach taken

is consistent with current theory and knowledge about the secondary effects of PTSD and shall provide a useful framework for understanding a complex issue that PTSD presents and its enormous impact on individuals, families and communities.

In addition to the experience of creating a model specifically for this proposal, another valuable lesson learned was the many unexpected nuances that must be addressed when submitting a research proposal to an institutional review board (IRB). The IRB system is a painstaking, yet essential procedural requirement that provides a number of safeguards to protect study participants and to ensure ethical, solid and useful information. While many may view the process as quite constraining, IRBs are indeed vital to protect human subjects in research.

B. Limitations

There a number of limitations that needs to be identified. First and foremost, this study is exploratory and qualitative in nature, so therefore, it is not generalize able. Another potential deficiency is validity. Even though the CAPS questions are considered the gold standard for diagnosing PTSD, the questions used for this study are being applied to physicians to gauge their comprehension and assessment of the secondary effects of PTSD and how it may impact family members and others living close to PTSD sufferers. The questions have been slightly modified in their content to measure specific components of PTSD rather than for diagnosis or determining severity. Another concern regarding this proposal centers on the training and experiences of physicians who work within the VA health care system. Due to the number of military personnel who are treated by VA physicians and similar clinicians, the professionals' preparation and level of expertise with PTSD patients would indicate that physicians and other

health care providers outside the VA health care system are at a disadvantage with respect to diagnosing and treating patients with PTSD. Furthermore, combat is only one subset of the many types of trauma that can occur and it would be unwise to assume that all individuals who experience traumatic events might have similar risks to develop PTSD.

Conclusion

A thorough literature review indicated a gap in understanding PTSD and the potential residual effects that need to be addressed. These issues are particularly relevant when considering the current wars in Iraq and Afghanistan and their impact on military personnel and their families. The implication of this study for physicians and clinicians is that living with a person who has PTSD symptoms has an important effect on family members. They must be aware that family members who live with PTSD sufferers may also experience negative health consequences thus following a systematic approach which addresses the residual impact of PTSD and promoting those factors that enhance resiliency may be the most effective approach in the treatment of individuals with PTSD. Although this study was unable to be concluded and no data was collected, the proposed research project provided a more comprehensive understanding of PTSD. This researcher shall be able to apply the lessons learned in practice by using a more “humanistic” model that emphasizes the qualities and acumen of the providers when working with clinicians who screen and treat military personnel for PTSD.

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Appendices

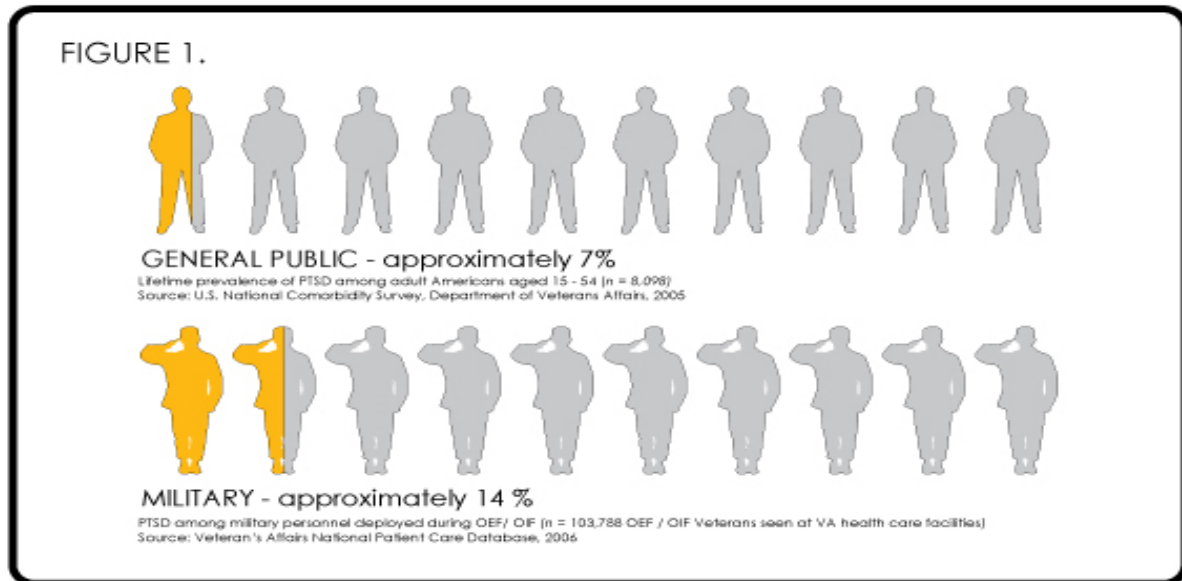


Figure 1: Comparison of prevalence of PTSD in General Public and Military Personnel

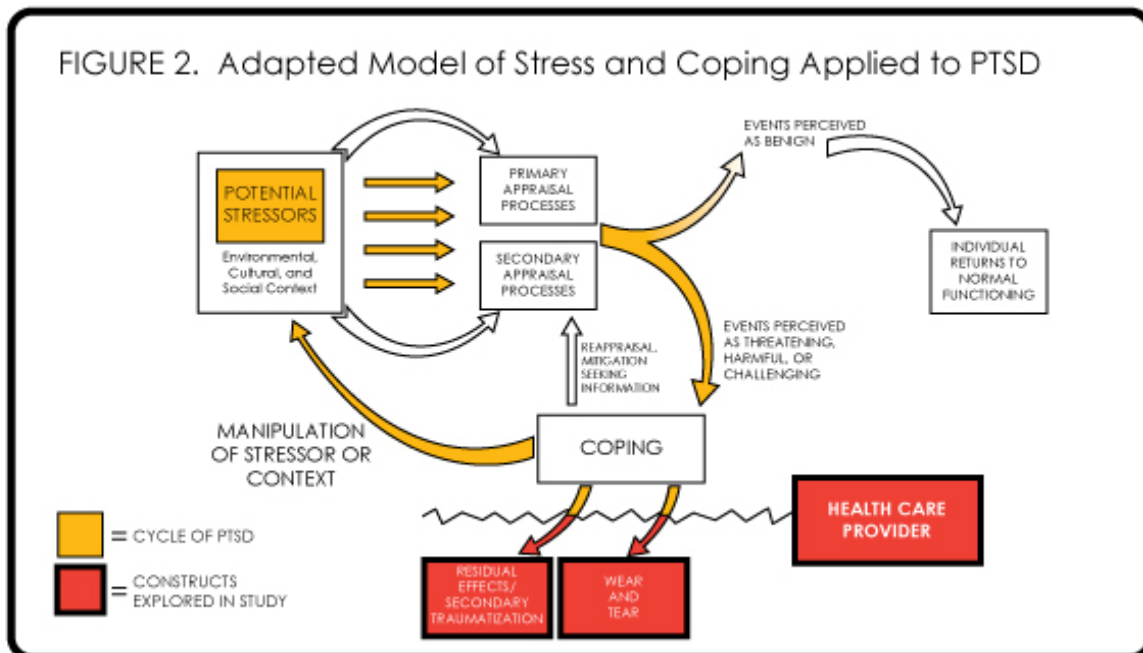


Figure 2: Adapted Stress and Coping Model used in Study

Fig

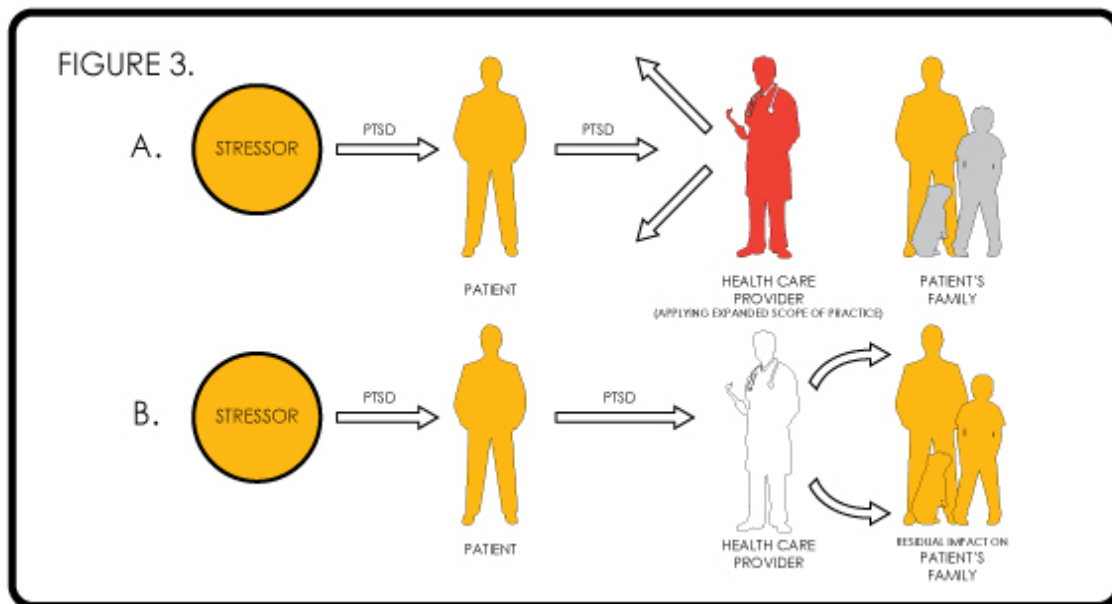


Figure 3: Current Methods and Residual Impact of PTSD

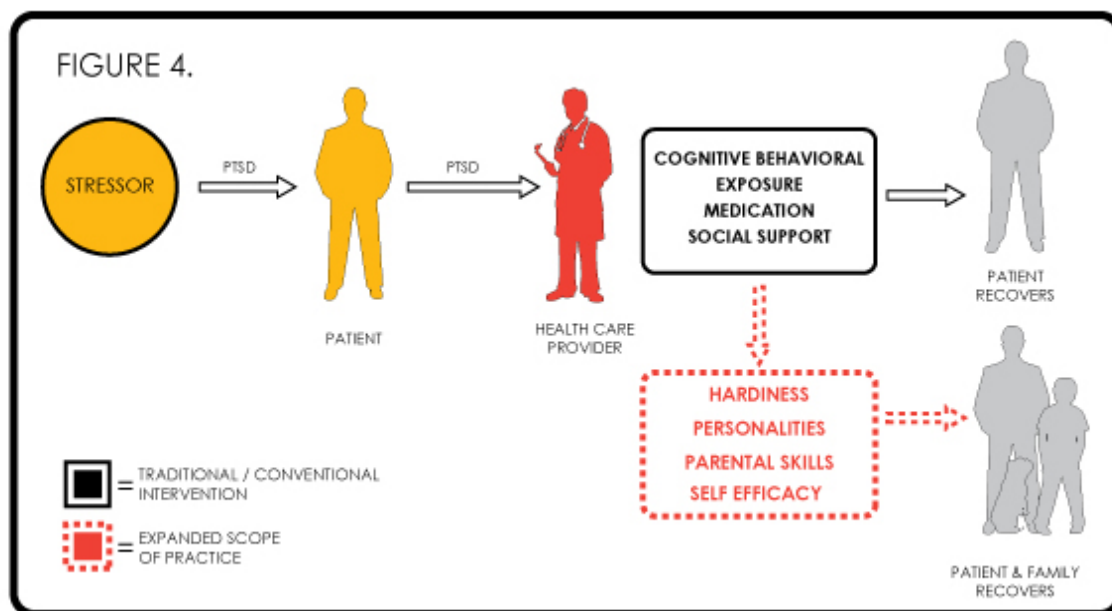


Figure 4: Expanded Scope of Practice

